

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

BP

DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR			REG. NO. 9 1 4 8 7 7						
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH DAY YEAR		2b. HOUR	
Mary G. Alford			June 13 79		7:15 AM				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
female		Caucasian		5-17-19		60		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
West Virginia		USA				Cecil MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Elkton		Union of Cecil County			Housewife				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?				
13a. STATE Maryland 13b. COUNTY Kent 13c. CITY OR TOWN Golts					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST NO Record					FIRST MIDDLE LAST NO Record				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
NO			190-12-9456		C. Edward Hamrick - West Chester, Pa.				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic obstructive lung disease</u> 496- DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Probable bronchiogenic carcinoma left upper lobe</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 75</u> , 19____, to <u>13 June</u> , 19 <u>79</u> , that (I) <del>was</del> lost saw the deceased alive on <u>13 June 79</u> , 19____, and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>did</del> view the body after death.									
22b. SIGNATURE <u>Wallace Obenshain M.D.</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>15 June 79</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wallace Obenshain M.D.					22e. ADDRESS Cecilton, Maryland 21913				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			June 18, 1979		Towrnsend Cem.		Towrnsend - N.C. Del.		
24. FUNERAL DIRECTOR <u>Robert C. Hutchinson - Middletown, Del.</u>					25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>JUN 26 1979</u> <u>Robert C. Hutchinson</u>				

14877



The following is a list of the  
 names of the persons who  
 were present at the meeting  
 held on the 1st day of  
 January, 1887.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1- FOR STATE REGISTRAR		7 9		1 4 8 7 8		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>Mattie Argo</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>June 17, 1979</b>			2b. HOUR <b>8:33 PM</b>			
3 SEX <b>female</b>		4 RACE <b>Caucasian</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>10-14-1884</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>94</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Delaware</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b> MD.					
10 CITY OR TOWN OF DEATH <b>Elkton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union of Cecil Co.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Delaware</b>					13b. COUNTY <b>New Castle</b>		13c. CITY OR TOWN <b>Newark</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Dill</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Clara (unknown)</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>221-50-4073</b>		17 INFORMANT ADDRESS <b>Cortlen J. Argo 2471 Summitt Br. Rd. Newark, Del 19702</b>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Severe Arteriosclerotic heart disease</b> <b>4-140</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <b>Possible lymphoma</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>June 76</b> , 19____, to <b>17 June 79</b> , 19____, that (I) (we) last saw the deceased alive on <b>17 June 79</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.											
22b. SIGNATURE <b>Wallace Obenshain, MD</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>18 June 79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Wallace Obenshain M.D.</b>						22e. ADDRESS <b>Cecilton, Maryland 21913</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6/21/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Odd Fellows Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Camden Kent Dela.</b>				
24. FUNERAL DIRECTOR <b>Wells A. Faries</b>						ADDRESS <b>Smyrna, Del.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 25 1979</b>		25b. REGISTRAR'S SIGNATURE <b>H. J. Kennedy</b>	

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DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Clyde R. Barr			2a. DATE OF DEATH MONTH DAY YEAR June 16, 1979			2b. HOUR 1:25AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9-17-1909		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.	
10. CITY OR TOWN OF DEATH Perry Point		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber		12b. KIND OF BUSINESS OR INDUSTRY Plumbing	
13a. STATE Md.		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Barr		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Long		13e. STREET ADDRESS 3722 - Ingalls Ave.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT Dolores A. Moreland		ADDRESS Same As Above	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, bilateral</u> <u>1629</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Post-op status for pneumonectomy, lower lobe, Rt lung, with metastasis to brain</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of Right lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (X) (this hospital) attended the deceased from <u>8-28-</u> 19 <u>78</u> , to <u>6-16-</u> 19 <u>79</u> , that (X) (we) last saw the deceased alive on <u>6-16-</u> 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did not view the body after death.							
22b. SIGNATURE A. L. Mooney M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6-18-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. L. MOONEY, M.D.				22e. ADDRESS VAMC Perry Point, Md.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-21-79		23c. NAME OF CEMETERY OR CREMATORY Cheltenham Vet. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham Cecil Md.	
24. FUNERAL DIRECTOR NAME Nalleys Funeral Home				ADDRESS Mt. Rainier, Md.		25a. DATE REC'D. BY REGISTRAR JUN 25 1979	
25b. REGISTRAR'S SIGNATURE Pietro MacBride							

4102 BP

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VA Medical Center

Harry Point

UNIT OF 2100

VA Medical Center

Harry Point



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14880

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Thomas Cooper</b>			2a. DATE OF DEATH MONTH <b>6</b> DAY <b>8</b> YEAR <b>79</b>			2b. HOUR <b>2:00pm</b>					
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>6</b> DAY <b>11</b> YEAR <b>20</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b>		8. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		9. IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b>					
10. CITY OR TOWN OF DEATH <b>Elkton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Hospital of Cecil Co.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Lineman</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Singer Corp.</b>		
13a. STATE <b>New York</b>		13b. COUNTY		13c. CITY OR TOWN <b>New York</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>3611 Gomer Street</b>			
14. FATHER'S NAME FIRST <b>Thomas</b> MIDDLE <b>Cooper</b> LAST <b>Cooper</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Lillian</b> MIDDLE <b>Cooper</b> LAST <b>Cooper</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>111-11-Navu</b>		16c. SOCIAL SECURITY NO. <b>131-03-0432</b>		17. INFORMANT ADDRESS <b>Heights, N. 9.</b> <b>Mrs. Betty Cooper, 3611 Gomer St., Yorktown</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> <b>410-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DOE TO, OR AS A CONSEQUENCE OF (b) _____ DOE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <b>05-19</b> , 19 <b>79</b> , to <b>06-08</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>06-08-79</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22a. SIGNATURE <b>Victor Magalong, M.D.</b>						DEGREE <b>M.D.</b>			22c. DATE SIGNED <b>06-08-79</b>		
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Victor Magalong, M.D.</b>						22e. ADDRESS <b>Newark, Delaware</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>June 13, 1979</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Lawn Croft Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Linwood</b> COUNTY <b>Delaware</b> STATE <b>Pa.</b>		
24. FUNERAL DIRECTOR NAME <b>Edward M. McKee</b>						25a. DATE OF BURIAL <b>JUN 12 1979</b>			25b. R. <b>1000</b>		

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 14881	
1. DECEASED NAME (TYPE OR PRINT) ELIZABETH D. CORRELL					2a. DATE OF DEATH MONTH DAY YEAR 6-24-1979			2b. HOUR 10 a M			
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 6-23-1898		6. AGE (IN YEARS LAST BIRTHDAY) 81		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.					
10. CITY OR TOWN OF DEATH Chesapeake City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Graham's Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Delaware		13b. CITY New Castle		13c. CITY OR TOWN Newark		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 300 West Chestnut Hill Road			
14. FATHER'S NAME FIRST MIDDLE LAST Henry Dunkleberger					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mame Brower						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 221-40-5288		17. INFORMANT ADDRESS Henry B. Correll RD #1 Bear Dela. 19701							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, Genitourinary infection.</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASHP, Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Organic brain syndrome</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Rheumatoid arthritis, Status. CVA. (old).</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Jui Chih Hsu</u>				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6-25-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jui Chih Hsu M.D.				22e. ADDRESS West Main Street, Elkton, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-26-79		23c. NAME OF CEMETERY OR CREMATORY Head of Christiana		23d. LOCATION CITY OR TOWN COUNTY STATE Newark, N.C. Dela.					
24. FUNERAL DIRECTOR NAME <u>William J. Warwick</u>				ADDRESS Newark, Del.		25a. DATE REC'D. BY REGISTRAR JUN 26 1979		25b. REGISTRAR'S SIGNATURE <u>Henry M. Brady</u>			

1884



1-11-1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 60M 1/75  
(VRA 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 14882		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
INA		M. DAVIDSON		JUNE 15, 1979				12:40 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Female		White		January 11, 1899		80 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.	
Pennsylvania		USA				Cecil			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Elkton		Union Hospital		Housewife					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Cecil		North East		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Lake Side Drive	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
-----		Leebody		Anna		No		215-30-4555 Mr. William Davidson, Ackron, Ohio	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4140		Pulmonary embolism		ASHD, CHF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF		Chronic lung disease, emphysema					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		7x of hip April 1979							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22. I certify that (1) this hospital attended the deceased from		5/29 19 77		to		6/13 19 79		that (1) we lost	
saw the deceased alive on		6/13 19 79		and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) we (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
Jui-Chih Hsu, M.D.						6/13/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Jui-Chih Hsu, M.D.		223 W. Main St. Elkton, Md.		Burial		6/19/79		Immaculate Conception Cemetery, Elkton, Maryland	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. SIGNATURE OF REGISTRAR			
HYCK'S HOME FOR FUNERALS		ELKTON, MD.		JUN 22 1979					

58-8471



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9		1 4 8 8 3		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Alfred H. Davis</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>June 4, 1979</b>			2b. HOUR <b>11 P.</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>August 16, 1888</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Elk Neck, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b> MD.			
10. CITY OR TOWN OF DEATH <b>Elkton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Laurelwood Nursing Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Md.</b>		13b. COUNTY <b>Cecil</b>		13c. CITY OR TOWN <b>Elkton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>204 Parkway</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George B. Davis</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Julia Hitchens</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>216-28-2533</b>		17. INFORMANT ADDRESS <b>Newark, Del.</b> <b>Helen R. McCauley 304 Beverly Ave.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> 42992 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Over 1 yr.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Senility and senile psychosis - arthritis, sv.</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>May 2, 1979</b> to <b>June 4, 1979</b> , that (I) (we) last saw the deceased alive on <b>June 4, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>S. Ralph Andrews</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>6/5/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S. Ralph Andrews, M.D.</b>				22e. ADDRESS <b>233 E. Main St., Elkton, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 8, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Elkton Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Elkton Cecil Md.</b>			
24. FUNERAL DIRECTOR NAME <b>SEE FUNERAL HOME</b> ADDRESS <b>Elkton, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 6 1979</b>					
				REGISTRAR'S SIGNATURE <b>Helen R. McCauley</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 14884	
1. FOR STATE REGISTRAR						2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) William F. Donatello						June 16, 1979		10:25P		M	
3 SEX Male		4 RACE Cau.		5 DATE OF BIRTH MONTH DAY YEAR August 13, 1925		6 AGE (IN YEARS LAST BIRTHDAY) 53 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.					
10. CITY OR TOWN OF DEATH Perry Point		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY -----			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Penna.						13b. COUNTY Chester		13c. CITY OR TOWN Chester		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME William F. Donatello, Sr.						15. MOTHER'S MAIDEN NAME Minney Mae Klies					
16a. WAS DECEASED EVER IN ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 206120904		17. INFORMANT ADDRESS Clara Ann Bailey, 217 Thurlow St. Chester, Pa.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute respiratory failure</b> 492- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic obstructive lung disease (emphysema)</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 5-25-19-78, to 6-16-19-79, that (we) last saw the deceased alive on 6-16-19-79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.											
22b. SIGNATURE A. L. Mooney, M.D.						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6-18-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. L. MOONEY, M.D.						22e. ADDRESS VA Medical Center, Perry Point, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 20, 1979		23c. NAME OF CEMETERY OR CREMATORY Immaculate Heart Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Linwood Delaware Penna.		25b. REGISTRAR'S SIGNATURE Jeffrey M. Brady			
24. FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Md.						25a. DATE REC'D. BY REGISTRAR JUN 19 1979					





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Army Joint Medical Center  
Fort Belvoir, Illinois  
August 15, 1957  
Dear Sir:  
Enclosed for you are two copies of a letterhead memorandum dated August 14, 1957, from the Surgeon General, Department of the Army, to the Surgeon, Army Medical Center, Fort Belvoir, Illinois, regarding the above captioned subject.  
Very truly yours,  
[Signature]

Chronic obstructive lung disease (emphysema)  
Acute respiratory failure

Very truly yours,  
A. J. MOONEY, M.D.  
Surgeon, Army Medical Center, Fort Belvoir, Illinois  
Enclosure  
6-18-57

BP

DHMH - 16 60M 1/75  
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 79 14885		1 DECEASED NAME (TYPE OR PRINT) <b>EDWARD C. EASTRIDGE</b>		2a DATE OF DEATH MONTH DAY YEAR <b>JUNE 4, 1979</b>		2b HOUR M	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>MAY 8, 1893</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b> MD			
10 CITY OR TOWN OF DEATH <b>Elkton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer - Elk Paper Co.</b>		12b KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b>				13b COUNTY <b>Cecil</b>		13c CITY OR TOWN <b>Elkton</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Melvin Eastridge</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Runalls</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>246-05-9753A</b>		17 INFORMANT ADDRESS <b>Mrs. Mary Ann Eastridge, Elkton, Md.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Arrhythmia</b> 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (b) <b>Q5HD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pneumonia</b>									
PART 2 - OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>2/5/68</b> , 19____, to <b>6/4</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/4</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <b>Joseph G. Lanzi, M.D.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>6/6/79</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS <b>Elkton Medical Park, Elkton, Md.</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/7/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Conowingo Baptist Cemetery, Conowingo, Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>HICKS HOME FOR FUNERALS, ELKTON, MD.</b>				ADDRESS		25a. DATE REC'D. BY REGISTRAR (2b REGISTRAR'S SIGNATURE) <b>JUN 14 1979</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR					REG. NO. 14886					
1. DECEASED NAME (TYPE OR PRINT) <i>Standley Evans, Sr.</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>May 16, 1979.</i>			2b. HOUR <i>10:30A</i>		
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>July 5, 1887</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>91</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil County</i> MD.				
10. CITY OR TOWN OF DEATH <i>Elkton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>216 East Main Street</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Laborer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Self-employed</i>		
13a. STATE <i>Maryland</i>					13b. COUNTY <i>Cecil</i>		13c. CITY OR TOWN <i>Elkton</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>William S. Evans</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Jennie Frazer</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>219-10-8420</i>		17. INFORMANT ADDRESS <i>Standley Evans, Jr. 216 E. Main St., Elkton, Md.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart Disease</i> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Years</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov</i> , 19 <i>78</i> , to <i>5-16-</i> , 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>May</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Tillman D. Johnson</i>				DEGREE <i>M.D.</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>5-16-79</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Tillman D. Johnson, M.D.</i>				22e. ADDRESS <i>123 Singereley Avenue, Elkton, Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>May 19, 1979</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Elkton Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Elkton Cecil Maryland</i>				
24. FUNERAL DIRECTOR <i>Joe Funeral Home</i>				ADDRESS <i>P.O. 259 E. Main St., Elkton, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>MAY 23 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Pitney McBrady</i>		

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14887	
1. DECEASED NAME (TYPE OR PRINT) <b>FRANK Lee GUSLER</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>6-23-1979</b>		2b. HOUR <b>9 A M</b>			
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH <b>11</b> DAY <b>11</b> YEAR <b>63</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>15</b> YRS.	IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>	IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	2c. DATE PRONOUNCED DEAD <b>6-23-1979</b>		2d. HOUR <b>6:22 P M</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b> MD.					
10. CITY OR TOWN OF DEATH <b>EIKTON</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>student</b>		12b. KIND OF BUSINESS OR INDUSTRY <b></b>			
13a. STATE <b>Penn.</b>			13b. COUNTY <b>Delaware</b>		13c. CITY OR TOWN <b>Chester</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>726 Highland Ave.</b>		
14. FATHER'S NAME FIRST <b>JUNIOR</b> MIDDLE <b>B.</b> LAST <b>GUSLER</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Connie</b> MIDDLE <b>R.</b> LAST <b>Kyle</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>			
16b. SOCIAL SECURITY NO. <b>211-52-5120</b>				17. INFORMANT <b>Connie Gusler</b>				17a. ADDRESS <b>726 Highland Ave Chester, PA.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> <b>9102</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>5 P.M. 6 23 19 79</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Fatigue while swimming</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>North East River</b>		21f. LOCATION STREET <b>North East River</b> CITY OR TOWN <b>Cecil</b> COUNTY <b>Del.</b> STATE <b>Md.</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Tillman D. Johnson</b>				TITLE (SPECIFY) <b>Deputy MEDICAL EXAMINER</b>				DATE SIGNED <b>6-23-79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Tillman D. Johnson</b>				ADDRESS <b>123 Singlerly Ave, EIKTON, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6-27-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LAWN CROFT Cem.</b>				23d. LOCATION CITY OR TOWN <b>Chichester Del.</b> COUNTY <b>Pa.</b> STATE <b>Pa.</b>			
24. FUNERAL DIRECTOR NAME <b>Gee Funeral Home</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 27 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Putnam</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Joseph L HALLERAN		June 26, 1979		11:15 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Male	White	June 19, 1890	89	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Penna.	U.S.A.		Cecil MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Perry Point, MD	Veterans Medical Center		Electrician		--
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
D.C.		Washington	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	6418 33rd. St.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
John Hatteran		Bridget (Unknown)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
Yes		175 24 5564	VAMC Records, Perry Point, Maryland.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest					
4292 DUE TO, OR AS A CONSEQUENCE OF (b) Heart failure					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease with Rt. Bundle-branch block & Lt. Anterior Hemiblock					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 8, 1972, to June 26, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Julian Oejo M.D.				6-27-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
JULIAN OCEJO, M.D.		VA Medical Center, Perry Point, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		July 2nd 1979	Culpeper National Cem.	Culpeper Virginia	
24. FUNERAL DIRECTOR		25. DATE REC'D.		25. REGISTRAR'S SIGNATURE	
Lee A. Patterson & Son, Perryville, Md.		JUL 6 1979			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Joe A. Patterson & Son, Perryville, Md.

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VA Medical Center, Perry Point, Md.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 9 1 4 8 8 9	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) George E HARMON						2a. DATE OF DEATH MONTH DAY YEAR June 23, 1979		2b. HOUR 10:45P M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 13 1925		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.					
10. CITY OR TOWN OF DEATH Perry Point		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Driver		12b. KIND OF BUSINESS OR INDUSTRY Taxi Cab			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Bethesda						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5101 Wislaming Road			
14. FATHER'S NAME FIRST MIDDLE LAST George Harmon				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia O'Brien							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW-II				16b. SOCIAL SECURITY NO. 216 20 0401		17. INFORMATION ADDRESS Bethesda, Md. 20016 Mrs. Nellie Sager, 5101 Wislaming Rd.,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 5719 DUE TO, OR AS A CONSEQUENCE OF (b) Chronic liver disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Arteriosclerotic coronary artery disease											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8-31-1976, to 6-23-79, that (we) lost the deceased alive on 6-23-1979, and that in my opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.											
22b. SIGNATURE A. L. Mooney M.D.						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 6-24-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. L. MOONEY, M.D.						22e. ADDRESS VAMC, Perry Point, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 27 June 1979		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore Md.	
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, Aberdeen, Md.						24b. ADDRESS 21001		25a. DATE REC'D. BY REGISTRAR JUN 28 1979		25b. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

DHMH - 16 50M 77/77  
(VR A 15 (4))

(M)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79 14890			
1- FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST EDWARD		MIDDLE M.		LAST HILL		JR.		2a. DATE OF DEATH MONTH DAY YEAR 6-4-79		2b. HOUR DOA 8:28 A M	
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 22, 1928		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Perry Point Cecil MD.							
10. CITY OR TOWN OF DEATH Perry Point		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Perry Point		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS V.A. Home					
14. FATHER'S NAME FIRST MIDDLE LAST Edward Hill		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Thelma Hilleary											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW 11		16b. SOCIAL SECURITY NO. 579-34-9019		17. INFORMANT Thelma Finocchiara		ADDRESS 54-47 Admiral Ave Middle Vil. N.Y.							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable acute myocardial infarction 410 - DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from June 4, 19 79, to June 4, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Ralph Twining, M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6-4-79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RALPH TWINING, M.D.		22e. ADDRESS VA Medical Center, Perry Point, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/7/79		23c. NAME OF CEMETERY OR CREMATORY Calverton National		23d. LOCATION CITY OR TOWN COUNTY STATE Calverton, Nassau N.Y.							
24. FUNERAL DIRECTOR NAME Hess-Miller Funeral Home, Middle Village, NY		25a. DATE REC'D. BY REGISTRAR JUN 12 1979		25b. REG. SIGNATURE [Signature]									

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The following table shows the results of the regression analysis for the dependent variable "Attitude towards the environment" (Table 1). The independent variables are "Age", "Gender", "Education", "Income", "Occupation", and "Experience". The table includes the coefficient, standard error, t-statistic, and p-value for each variable. The overall F-statistic is 10.23, and the adjusted R-squared is 0.68.

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SECRET - JUNE 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 4 8 9 3

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Louis G. Jefferis</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 1, 1979</b>			2b. HOUR <b>8:25</b> M				
3. SEX <b>M</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 9 1979 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>2 3 4 5</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil Co</b> MD.				
10. CITY OR TOWN OF DEATH <b>Perry Point, Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Veterans Administration Med. Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Painter</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Md</b>			13b. COUNTY <b>Cecil</b>		13c. CITY OR TOWN <b>Charlestown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>P.O. Box 173</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edwin S. Jefferis</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nettie Boyer</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>			16b. SOCIAL SECURITY NO. <b>180 07 8071</b>		17. INFORMANT <b>F. Jane Taylor, P.O. Box 173, Charlestown,</b>		ADDRESS <b>Md. 21914</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4140</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Nephrosclerosis and Aneurysm of Abdominal Aorta</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>May 31</b> , 19 <b>79</b> , to <b>June 1</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on _____, 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Klaus H. Huebner</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>June 1, 1979</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KLAUS H. HUEBNER, M.D.</b>				22e. ADDRESS <b>VAMC, Perry Point, Md. 21902</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 4 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Union Hill Cemy</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Kennett Twp, Chester Pa</b>				
24. FUNERAL DIRECTOR NAME <b>HICKS FUNERAL HOME, BALTIMORE, MD.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 5 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Jeffrey M. Brady</b>				
26. FUNERAL HOME <b>Kuzo Funeral Home, Kennett Square, Pa.</b>										

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DHMH - 16 50M 7/77  
(VR A 15 (4))



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 4 8 9 4

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>MANUEL JOHNSON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 21, 1979</b>		2b. HOUR <b>7:05a</b>
3 SEX <b>Male</b>	4 RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>March 28, 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Seattle, Washington</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b> MD.			10. CITY OR TOWN OF DEATH <b>Perry Point</b>		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA Medical Center</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Elevator Operator</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Wash., D.C.</b>			13b. COUNTY <b>Dist. of Col.</b>		
13c. CITY OR TOWN <b>Wash., D.C.</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS <b>1437 Girard St., N.W. Wash. D.C.</b>			14. FATHER'S NAME FIRST MIDDLE LAST <b>William Johnson</b>		
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jean Unknown</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>V917-1919</b>			17. INFORMANT ADDRESS <b>VAH Perry Point, Md. Records</b>		
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Uremia and bronchopneumonia</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 10</b> , 19 <b>75</b> , to <b>June 21</b> , 19 <b>79</b> . <del>XXXXXX</del> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I/we did not view the body after death)					
22b. SIGNATURE <b>Julian Ocejo, M.D.</b>		DEGREE		22c. DATE SIGNED <b>6-25-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JULIAN OCEJO, M.D.</b>		22e. ADDRESS <b>VA Medical Center, Perry Point, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (TYPE) <b>Burial</b>		23b. DATE <b>June 28, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Culpepper National Cem. Culpepper</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cecil Va.</b>		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>JUL 6 1979</b>			
24. FUNERAL DIRECTOR <b>Lee A. Patterson &amp; Son, Perryville, Md.</b>					

MEDICAL CERTIFICATION

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7:00A

June 21, 1979

JOHNSON

MILNER

(Call)

VA Medical Center

Forty Point

277-52-0278

Heart Failure

Uremia and bronchopneumonia

June 10

June 21

6-25-79

VA Medical Center, Forty Point, Md.

JULIAN 00110, 1.0.

Dr. J. Patterson & Son, Bryn Mawr, Pa.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 should be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO. 7 9 1 4 8 9 5					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Anthony P KLOSEK Sr</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>June 28, 1979</b>			2b. HOUR <b>8:20 P.M.</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 13 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. <b>Separated</b> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b> MD.				
10. CITY OR TOWN OF DEATH <b>Perry Point</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA Medical Center, Perry Point, Md</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Yacht Co.</b>		
13a. STATE <b>Maryland</b>					13b. COUNTY <b>City</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Klosek</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sophia Kalinowski</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes WW-II</b>					16b. SOCIAL SECURITY NO. <b>213 09 9317</b>		17. INFORMANT ADDRESS <b>Anthony P. Klosek, Jr., 1109 Wholen Way, Baltimore, Maryland 21224</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Bronchopneumonia</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <b>A.S.C.V.D.</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 31</b> , 19 <b>69</b> , to <b>June 28</b> , 19 <b>79</b> .										
22b. SIGNATURE <b>Prem Lal Prem Lal MD</b> DEGREE <b>Asst. O/D</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Prem Lal</b>					22e. ADDRESS <b>VAMC, Perry Point, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2 July 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cheltenham Md. Veterans</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cheltenham Prince George Md.</b>				
24. FUNERAL DIRECTOR NAME <b>Tarring Funeral Homes</b>					24b. ADDRESS <b>333 S. Parke St., Aberdeen, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 2 1979</b>		25b. REG. NO. <b>7 9 1 4 8 9 5</b>	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IN EXECUTION, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH-17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14896

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Alvin Blaine Lester</b>						2a. DATE OF DEATH KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6 24 1979</b>			2b. HOUR M <b>3:00p</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 28, 1939</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>40 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS <b>0 0</b>		IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil County</b> MD				
10. CITY OR TOWN OF DEATH <b>Elkton</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Rt. 40 &amp; Landing Lane</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpenter</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
13a. STATE <b>Virginia</b>			13b. COUNTY <b>Alexandria</b>			13c. CITY OR TOWN <b>Alexandria</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>20 Ivan Place</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles McKinley Lester</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ethel Meadows Vance</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1957-1959</b>			17. INFORMANT <b>Grace D. Lester</b>			ADDRESS <b>Same</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound to chest (handgun)</b> 9550 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOURS MONTH DAY YEAR <b>2:30 P.M. 6 24 1979</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>self inflicted</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>restaurant</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Rt. 40 &amp; Landing Lane, Elkton, Cecil MD</b>					
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Thomas D. Smith</i>				TITLE (SPECIFY) <b>Deputy Chief</b>				DATE SIGNED <b>6/25/79</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>				ADDRESS <b>111 Penn St. Balto., MD</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Transit-Burial</b>				23b. DATE <b>June 27, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Family Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bartley West Va.</b>			
24. FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home, Inc.</b>				ADDRESS <b>6500 York Rd. Balto., Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 26 1979</b>		25b. REGISTRAR'S SIGNATURE <i>Robert H. Smith</i>			

1 4 8 9 3



CONFIDENTIAL

2500 YORK ST.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14897

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>THOMPSON A LYON JR</b>			2a DATE OF DEATH MONTH DAY YEAR <b>6-21-79</b>			2b HOUR <b>1050 AM</b>			
3 SEX <b>M</b>		4 RACE <b>W</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>3 14 20</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>59</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>CECIL</b> MD.			
10 CITY OR TOWN OF DEATH <b>ELKTON</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION</b>				12a USUAL OCCUPATION (IF WORK FOR MOST OF WORKING LIFE) <b>RET CONST BKG GOUT</b>		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE <b>MD</b>			13b CITY OR TOWN <b>CECIL</b>		13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d STREET ADDRESS <b>BOX 56</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>THOMPSON A. LYON SR</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CORNILIA NO INFO</b>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>NW- 219-01-7551</b>		17 INFORMANT ADDRESS <b>PATRICIA T. LYON CITY MD</b>				
18 CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE 1a) <b>LARYNGEAL</b> <b>1619</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause 1a), stating the underlying cause lost b) <b>CARCINOMA OF THE LARYNX</b> DUE TO, OR AS A CONSEQUENCE OF c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 1a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from <b>6-12-79</b> 19 <b>79</b> to <b>6-21</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6-21</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <i>Rolando A. Madera</i>			DEGREE			22c DATE SIGNED <b>6-21-79</b>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROLANDO A. MADERA</b>			22e ADDRESS <b>105 E. MAIN ELKTON, MD</b>						
23a BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <b>CREMATION</b>			23b DATE <b>6-25-79</b>		23c NAME OF CEMETERY OR CREMATORY <b>CRATIN + FERRIS</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>WEST CHESTER PA</b>		
24 FUNERAL DIRECTOR NAME <b>R.T. FORD FUNERAL HOME</b>			ADDRESS <b>CITY MD</b>		25a DATE REC'D BY REGISTRAR <b>JUN 25 1979</b>		25b REGISTRAR'S SIGNATURE <i>Patricia M. Brady</i>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

7 6 5 4 3 2 1

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE FILED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP ✓  
DHMH - 17  
(VR A15 ME (5))  
30M 7/73

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										1 4 8 9 8 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>Willard William McKinney, Jr.</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>6-7-1979</b>										2b. HOUR <b>1:30</b> A M				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>Feb.</b> DAY <b>23</b> YEAR <b>27</b>		6. AGE (IN YEARS) LAST BIRTHDAY) <b>52</b> YRS.		IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD <b>6-7-1979</b>										2d. HOUR <b>1:50</b> A M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b> MD.												
10. CITY OR TOWN OF DEATH <b>Elkton</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Hosp. Elkton, MD.</b>								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpenter</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Rail Road</b>								
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																								
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Cecil</b>		13c. CITY OR TOWN <b>North East</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>121 E. Cecil Ave.</b>														
14. FATHER'S NAME FIRST <b>Willard</b> MIDDLE <b>W.</b> LAST <b>McKinney, Sr.</b>										15. MOTHER'S MAIDEN NAME FIRST <b>Henrietta</b> MIDDLE <b>F.</b> LAST <b>Ford</b>														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>WW 11</b>		17. INFORMANT <b>Henrietta F. McKinney</b>				ADDRESS <b>North East</b>														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>4-140</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																								
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																								
ACTUAL SIGNATURE <i>T. J. J. J.</i>										TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER										DATE SIGNED <b>6-7-79</b>				
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>					23b. DATE <b>6-11-79</b>					23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary Anne's</b>					23d. LOCATION CITY OR TOWN <b>North East</b> COUNTY <b>Cecil</b> STATE <b>Maryland</b>									
24. FUNERAL DIRECTOR <i>Paul R. R.</i>										25a. DATE REC'D. BY REGISTRAR <b>JUN 19 1979</b>					25b. REGISTRAR'S SIGNATURE <i>Robert McCreedy</i>									

North East

JUN 19 1979

Robert McCreedy

89841 95



FOR STATE  
HEALTH DEPT.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 4 8 9 9

1. DECEASED-NAME (Type or Print) <u>Kenneth S. McLEAN</u>			2a. DATE KNOWN OF ESTI-DEATH MATED <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year <u>1979</u>			2b. HOUR <u>CA. M</u>		
3. SEX <u>M</u>	4. RACE <u>W</u>	5. DATE OF BIRTH <u>5-23-13</u>	6. AGE (In years last birthday) <u>66</u> YRS.	IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u>	IF UNDER 24 HRS HOURS <u>0</u> MIN <u>0</u>	2c. DATE PRONOUNCED DEAD Month <u>4</u> Day <u>1</u> Year <u>1979</u>		
7a. BIRTHPLACE (State or foreign country) <u>CANADA</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>CECIL</u>		
10. CITY OR TOWN OF DEATH <u>ELKTON</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>UNION</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>RET. RADIO OPER.</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>SHIPPING</u>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD</u>			13b. COUNTY <u>CECIL</u>		13c. CITY OR TOWN <u>CHESAPEAKE CITY</u>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>BOHEMIA AVE</u>
14. FATHER'S NAME First <u>KENNETH G.</u> Middle <u>MCLEAN</u> Last <u></u>				15. MOTHER'S MAIDEN NAME First <u>ELIZABETH A.</u> Middle <u>STANLEY</u> Last <u></u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>WEL</u> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <u>102-07-9803</u>		17. INFORMANT <u>PAUL RODGERS</u>			ADDRESS <u>CHESAPEAKE CITY MD</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>4140</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <u>19</u> HOUR A.M. <u></u> P.M. <u></u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. <u></u> City or Town <u></u> County <u></u> State <u></u>				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <u>Tillman Johnson</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <u>6-1-79</u>		
EXAMINER'S NAME (Type) <u>Tillman Johnson</u>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) <u>Elkton, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>6-4-79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BETHEL</u>		23d. LOCATION (City or Town) (County) (State) <u>CHESAPEAKE CITY CECIL MD</u>		
24. FUNERAL DIRECTOR <u>Robert A. Ford</u> ADDRESS <u>CHESAPEAKE CITY MD</u>				25a. REC'D BY REGISTRAR <u>JUN 6 1979</u>		25b. REGISTRAR'S SIGNATURE <u>Patrick McCreedy</u>		

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours

after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



99841 97

MADE IN THE U.S.A.

MADE IN THE U.S.A.



COLLECTION SHEET



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 14900							
1. DECEASED NAME (TYPE OR PRINT)		Charles J. McQuaid, Sr.				2a. DATE OF DEATH		2b. HOUR	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Male		White		Apr 22 1896		83 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. HOUR	
Md.		U.S.A.				Perry Point, Md.		June 24, 1979 10:15A M	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Perry Point		Veteran's Hosp.-Perry Point				Photo Engraver			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md.		Balto.		Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6621 Loch Raven Blvd.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
Vincent		Leo McQuaid				Margaret Burns			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
Yes		WW I		217 05 5337		Chas. McQuaid Jr. (son) Dr., BelAir			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Shock									
4140 DUE TO, OR AS A CONSEQUENCE OF (b) Heart failure									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic heart disease and cancer of lung									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN COUNTY STATE			
22a. I certify that (if (this hospital) attended the deceased from 3-31-1976, to 6-24-1979, that (we) last saw the deceased alive on 6-24-1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (do not) view the body after death.									
22b. SIGNATURE		DEGREE				22c. DATE SIGNED			
JULIAN OCEJO, M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
JULIAN OCEJO, M.D.		VAMC, Perry Point, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. STATE	
Burial		6/27/79		Holy Redeemer		Balto.		Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Schimunek Funeral Home, Inc.		3321 Brehms Lane Balto. Md. 21213				JUN 26 1979			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR 1 - STATE REGISTRAR		7 9 1 4 9 0 1	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH MONTH DAY YEAR	
George Ernest Michael, Jr.		June 3, 1979	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)
Male	White	July 26, 1924	54 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.		Cecil MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR BALTIMORE)	12b. KIND OF BUSINESS OR INDUSTRY
Perry Point	Perry Point V A Hospital	Banker-Suburban Trust	Banking
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	
Maryland	Baltimore	Parkville	8641 Hoerner Avenue
14 FATHER'S NAME	15 MOTHER'S MAIDEN NAME		
George	Freda	Morgreth	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT	ADDRESS
Yes	WW 2	VAMC Records,	Perry Point, Maryland
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory alkalosis secondary to hyper-ventilation</u> 2396 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF <u>Brain tumor and pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>10-15-1975</u> to <u>6-3-1979</u> , that (X) (we) lost saw the deceased alive on <u>6-3-1979</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did not view the body after death.			
22b. SIGNATURE <u>Joseph Coudon M.D.</u>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH COUDON, M.D.		22e. ADDRESS VAMC, Perry Point, Maryland	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	6-6-1979	Parkwood	Baltimore Maryland
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Leonard J. Ruck, Inc. 5305 Harford Rd. Balto: Md.		JUN 6 1979	<u>Henry McBrady</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR			7 9 1 4 9 0 2 REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH		DAY		YEAR		2b. HOUR	
Larry P. O'PATTERSON			June 12, 1979								7:05 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS, LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Male		White		2-5-96		83		YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Va		USA				Ceel Co. MD.							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Perry Point, MD			Veterans Medical Center			Mechanics			Electrical				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
Md			AA		Arnold		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		218 Baybourne Dr.				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
Unknown			Unknown										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
Yes			217 32 7923			Hosp. Records							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis with Rt. Hemiplegia 4370 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Contributory Bronchial Pneumonia													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (this hospital) attended the deceased from February 22, 1974, to June 12, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (I) (we) (I) did not view the body after death.													
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED				
R. H. Twining, Jr. M.D.									6-12-79				
22d. PHYSICIAN'S NAME			22e. ADDRESS										
			VA Medical Center, Perry Point, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			6-14-79			Maryland New			Pachville			Baltimore	
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Barranco Funeral Home, Severn			Park, Md.			JUN 15 1979							



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FBI - NEW YORK



TO : DIRECTOR, FBI (100-441100)  
FROM : SAC, NEW YORK (100-111111)  
SUBJECT: [Illegible]  
[The remainder of the document contains several paragraphs of extremely faint, illegible text, likely a memorandum or report.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 14903

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST WILLIAM	MIDDLE J.	LAST PARE	2a. DATE OF DEATH	MONTH June	DAY 7	YEAR 1979	2b. HOUR 1:05pm
3 SEX Male	4. RACE White	5. DATE OF BIRTH MONTH Mr. 5 DAY 1919 YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Rhode Island	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.								
10. CITY OR TOWN OF DEATH Perry Point	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Air Force						
13a. STATE Maryland		13b. COUNTY Cecil	13c. CITY OR TOWN North East		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5 Beech St.				
14. FATHER'S NAME FIRST William A. LAST Bare		15. MOTHER'S MAIDEN NAME FIRST Margaret MIDDLE Davidson LAST									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II-Kor. 035-14-3350		17. INFORMANT ADDRESS Delbert W. Atkinson 5 Beech St.							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 4140 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which } (b) Arteriosclerotic heart disease gave rise to immediate } cause (a), stating the } underlying cause last } (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cerebral arteriosclerosis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (this hospital) attended the deceased from June 6, 1979, to June 7, 1979. <del>XXXXXX</del> I saw the deceased alive on June 6, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Klaus H. Huebner		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6-7-79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. H. HUEBNER, M.D.		22e. ADDRESS VA Medical Center, Perry Point, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-13-79		23c. NAME OF CEMETERY OR CREMATORY Culpeper National		23d. LOCATION CITY OR TOWN COUNTY STATE Culpeper VA.					
24. FUNERAL DIRECTOR NAME Crouse Funeral Home, North East, Md.						25a. DATE REC'D. BY REGISTRAR JUN 13 1979					
						25b. REGISTRAR'S SIGNATURE Anthony McCrady					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 14904	
1. DECEASED NAME (TYPE OR PRINT) John Wells Poe						2a. DATE OF DEATH MONTH DAY YEAR June 25, 1979		2b. HOUR 2:00A M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 9, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.					
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital of Cecil County				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance		12b. KIND OF BUSINESS OR INDUSTRY Thiokol			
13a. STATE Del. Md.						13b. COUNTY Cecil		13c. CITY OR TOWN Elkton			
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						13e. STREET ADDRESS Blue Ball Road					
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Poe				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Gilley							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 245-01-5921		17. INFORMANT ADDRESS Mr. Dale Poe, 13 Vassar Ave., New Castle, Dela.							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTING HEART FAILURE 496- DUE TO, OR AS A CONSEQUENCE OF (b) SEVERE COPD Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 6-6-1979 to 6-28-1979, that (I) (we) last saw the deceased alive on 6-28-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Rolando Najera, M.D.				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/28/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rolando Najera, M.D.				22e. ADDRESS East Main Street, Elkton, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 27, 1979		23c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Elkton Cecil Maryland		25a. DATE REC'D BY REGISTRAR JUN 29 1979			
24. FUNERAL DIRECTOR NAME ADDRESS Gee Funeral Home, P.A. 259 E. Main St., Elkton, Md.											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7. REG. NO. <b>78-32470</b>							
1. DECEASED NAME (TYPE OR PRINT) <b>Lewis A. Quirk</b>				7a. DATE OF DEATH MONTH DAY YEAR <b>June 13, 1978</b>				7b. HOUR <b>8:55A. M.</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 5, 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.		8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b> MD.			
10. CITY OR TOWN OF DEATH <b>Perry Point</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Veterans Administration Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Trainman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Penna. R.R.</b>	
13a. STATE <b>D.C.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4228 Fessenden, N.W.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW 11</b>		17. INFORMANT ADDRESS <b>V.A.H. Records, Perry Point, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral</b> <b>1539</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Metastatic tumor nodules to lungs</b> (c) <b>Carcinoma of colon with metastasis</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>June 20</b> , 19 <b>72</b> , to <b>June 13</b> , 19 <b>78</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>A. L. Mooney, M.D.</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. L. Mooney, M.D.</b>				22e. ADDRESS <b>VAH, Perry Point, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 16, 1978</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Culpeper National</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Culpeper, Culpeper, Virginia</b>			
24. FUNERAL DIRECTOR NAME <b>Lee A. Patterson &amp; Son, Perryville, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 19 1978</b>		25b. REGISTRAR'S SIGNATURE <b>Robert M. ...</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 4 must be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79 14906	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <b>Herman Ross</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>June 5, 1979</b>			2b. HOUR <b>4:00 A.M.</b>			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 16, 1916</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b> MD.					
10. CITY OR TOWN OF DEATH <b>North East</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Route 7</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Construction</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Route 7</b>				
13a. STATE <b>Md.</b>		13b. COUNTY <b>Cecil</b>		13c. CITY OR TOWN <b>North East</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>John M. Ross</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alice Blackwell</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>228-09-7671</b>		17. INFORMANT ADDRESS <b>Carl J. Ross North East, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 HRS.</b>		
410- <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ABSCISSA; CORONARY ARTERY DISEASE</b>									<b>YEARS</b>		
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>5:22 64 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>5-18</b> 19 <b>77</b> to <b>64</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>5-18</b> 19 <b>77</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)											
22b. SIGNATURE <b>Barry R. Barnhart</b> DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6-5-79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Barry R. Barnhart</b>					22e. ADDRESS <b>3 Mauldin Ave. North East, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6-8-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Union</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Elkton Cecil Md.</b>				
24. FUNERAL DIRECTOR NAME <b>Paul R. Couch</b> ADDRESS <b>North East, Md.</b>					25a. DATE REC'D. BY REGISTRAR <b>JUN 6 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert McCreedy</b>				



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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

14907

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTHS DAYS HOURS MIN.	
FIRST MIDDLE LAST		6-8-1979		7:30 a.m.	
Myrtle J. Scott					
3. SEX		4. RACE		5. DATE OF BIRTH	
Female		Cauc.		11-20-1889	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)	
Delaware		U.S.A.		89	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
Elkton		Union Hospital		Cecil	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		MD.	
Housewife					
13a. STATE		13b. CITY OR TOWN		13c. STREET ADDRESS	
Delaware		New Castle		168 East Main Street	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Unknown		Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Newark	
				Robert L. Scott, 28 N Chaple St. Delaware	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <i>cardiac arrest</i>					
4149					
DUE TO, OR AS A CONSEQUENCE OF					
(b) <i>coronary disease and congestive failure</i>					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>6</i> 19 <i>78</i> , to <i>6</i> 19 <i>79</i> , that (I) (we) lost saw the deceased alive on <i>6/8</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<i>James R. Dearworth M.D.</i>				6-8-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
James R. Dearworth M.D.		167 W. Main St. Newark, Delaware			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		6-11-79		Newark M.E. Cem	
24. FUNERAL DIRECTOR		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS		Newark, Del.		JUN 12 1979	
<i>William J. Harwick</i>				<i>Anthony McCreedy</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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NOT FOR CIRCULATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires, that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		7 9 1 4 9 0 8		REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) <b>John</b> <sup>FIRST</sup> <b>Roland</b> <sup>MIDDLE</sup> <b>Shaffer</b> <sup>LAST</sup>				2a. DATE OF DEATH MONTH DAY YEAR <b>June 6 1979</b>		2b. HOUR <b>12:00</b> <sup>AM</sup>			
3. SEX <b>M</b>		4 RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8/10/63</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b> <b>MD</b> <b>COUNTY</b>			
10. CITY OR TOWN OF DEATH <b>PERRY PT.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VAMC, Perry Point, Maryland</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BREWERY</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD.</b>		13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>ESSEX</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1017 FOXWOOD LN</b>	
14. FATHER'S NAME FIRST <b>UNK</b> MIDDLE <b>UNK</b> LAST <b>UNK</b>				15. MOTHER'S MAIDEN NAME FIRST <b>UNK</b> MIDDLE <b>UNK</b> LAST <b>UNK</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>160120321</b>		17. INFORMANT <b>ANNA MAE SHAFER</b>		ADDRESS <b>ABOVE</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4280</b> IMMEDIATE CAUSE (a) <b>Circulatory failure</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive Heartfailure</b>									
DUE TO, OR AS A CONSEQUENCE OF (c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Bum S. Lee M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						22c. DATE SIGNED <b>6-7-79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Bum Soo Lee</b>				22e. ADDRESS <b>VAMC, Perry Point, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6/9/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LAKE VIEW</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD</b>			
24. FUNERAL DIRECTOR NAME <b>Connelly Funeral Home</b> ADDRESS <b>300 Mace Ave, Balto, Md</b>				25a. DATE RECD. BY REGISTRAR <b>JUN 11 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Jeffrey McBrady</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 14909									
1. DECEASED NAME (TYPE OR PRINT)		FIRST HENRY		MIDDLE R.		LAST SHANK		2a. DATE OF DEATH MONTH DAY YEAR 6 12 79		2b. HOUR 3:35 P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 7 03		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co. MD					
10. CITY OR TOWN OF DEATH Elkton, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital				12a. USUAL OCCUPATION (TYPE OF WORK OR INDUSTRY) Self-employed Contractor-Builder, Real Estate		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 200 Landing Lane			
14. FATHER'S NAME FIRST MIDDLE LAST Henry				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-20-5442		17. INFORMANT ADDRESS Mr. Robert J. Shank, Bear, Delaware							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 410- DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC HEART ACS.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from 6-11, 19 79, to 6-12, 19 79, that (I) (we) last saw the deceased alive on 6-12, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Rolando A. Najera				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6/12/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rolando A. Najera, M.D.				22e. ADDRESS 105 E. Main Street, Elkton, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/14/79		23c. NAME OF CEMETERY OR CREMATORY West Nottingham Presbyterian, W. Nottingham, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME Donald S. Hicks				ADDRESS HICKS HOME for FUNERALS, ELKTON, MD.				25a. DATE REC'D. BY REGISTRAR JUN 18 1979		25b. REGISTRAR'S SIGNATURE Henry McCreedy	

(M)

MEDICAL CERTIFICATION

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904-1297



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 79 14910							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Walter Lee White						2a. DATE OF DEATH MONTH DAY YEAR June 8 1979		2b. HOUR 4:40A <sub>M</sub>	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 1, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.			
10. CITY OR TOWN OF DEATH Perry Point		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC, Perry Point, Maryland				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Miner		12b. KIND OF BUSINESS OR INDUSTRY Coal	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Harford Abingdon						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3803 Longley Road	
14. FATHER'S NAME FIRST MIDDLE LAST William ---D. White				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary --- Mitchell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ADDRESS Calip John White, Abingdon, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrhythmia 410- } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which } (b) Myocardial Infarction gave rise to immediate } cause (a), stating the } underlying cause last. } (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Prem Lal				DEGREE M.D., ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 6-8-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Prem Lal				22e. ADDRESS VAMC, Perry Point, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 11, 1979		23c. NAME OF CEMETERY OR CREMATORY Angel Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Havre de Grace-Harford-Md.			
24. FUNERAL DIRECTOR NAME Howard K McComas III				ADDRESS Abingdon, Maryland		25a. DATE REC'D. BY REGISTRAR JUN 12 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14911									
1. DECEASED NAME (TYPE OR PRINT) <b>Edward Harrison Williams, Sr.</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6-23 1979</b>		2b. HOUR <b>12:15 PM</b>							
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Apr. 10 15</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>64 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD <b>6-25 1979</b>		2d. HOUR <b>13:20 PM</b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b> MD.							
10. CITY OR TOWN OF DEATH <b>Elkton</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Hosp. Elkton, MD.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ins. Agent</b>				12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Cecil</b>				13c. CITY OR TOWN <b>Elkton</b>				13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS <b>250 Nellies Corner Rd.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>James B. Williams</b>								15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rose I. Williams</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>216-06-3900</b>				17. INFORMANT ADDRESS <b>Dorothy T. Williams Elkton, MD.</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <b>Tillman D. Johnson</b>				TITLE (SPECIFY) <b>Deputy Medical Examiner</b>				DATE SIGNED <b>6-23-79</b>											
EXAMINER'S NAME (TYPE OR PRINT) <b>Tillman D. Johnson MD</b>				ADDRESS <b>123 Singlerly Ave. Elkton, MD.</b>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>6-27-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sharps Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Fair Hill Cecil Maryland</b>									
24. FUNERAL DIRECTOR NAME <b>Paul G. Crouch</b>				ADDRESS <b>North East, MD.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 27 1979</b>				25b. REGISTRAR'S SIGNATURE <b>Dorothy McCreedy</b>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
REG. NO. 79 14912									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JAMES ALBERT WILSON, Sr.</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>June 16, 1979</b>		2b. HOUR <b>6 P. M.</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April, 19, 1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b> MD.			
10. CITY OR TOWN OF DEATH <b>R.D. Earleville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farming</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Md.</b>		13b. COUNTY <b>Cecil</b>		13c. CITY OR TOWN <b>Earleville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rich Neck Farm</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jonas Wilson</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Melawalka Nichols</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-12-5602</b>		17. INFORMANT ADDRESS <b>Mrs. Elsie V. Wilson, Earleville, Md. 21919</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4254</b> IMMEDIATE CAUSE (a) <b>Cardiomyopathy, arteriosclerotic</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>two years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. certify that (I) (this hospital) attended the deceased from <b>June 77</b> , 19____, to <b>16 June</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>16 June</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Wallace Obenshain M.D.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>18 June 79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Wallace Obenshain, M.D.</b>				22e. ADDRESS <b>Cecilton, Md. 21913</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/19/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Earleville Cecil Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Howard E. Fellows, Millington, Md. 21651</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 25 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert McCready</b>			

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S I R A I V





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of course.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79 14913	
1- FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PAUL WOLF				2a. DATE OF DEATH MONTH DAY YEAR 6 7 79		2b. HOUR M			
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 10-4-99		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 79		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CECIL MD.					
10. CITY OR TOWN OF DEATH ELKTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MECHANIC		12b. KIND OF BUSINESS OR INDUSTRY PUBLIC SERVICE			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD		13b. CITY OR TOWN CECIL		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS RX 213 BOX 28					
14. FATHER'S NAME FIRST MIDDLE LAST NO INFO				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NO INFO							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS NELLIE GARRIGAN EARLEVILLE MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the left lung 1629 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 19 mos	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1 Mar 79, 19, to June 1 79, 19, that (I) (we) lost saw the deceased alive on 1 June 79, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.											
22b. SIGNATURE Wallace Obenshain				DEGREE M.D.				22c. DATE SIGNED 3 June 79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wallace Obenshain, M.D.				22e. ADDRESS Cecilton, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6-5-79		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON				23d. LOCATION CITY OR TOWN COUNTY STATE KEARNY N.J.			
24. FUNERAL DIRECTOR NAME R.T. FORD				25. DATE REC'D. BY REGISTRAR JUN 6 1979				25b. REGISTRAR'S SIGNATURE [Signature]			



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Department of the Army

June 10

Washington, D.C.

Office of the Adjutant General

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79 14914

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>RONALD E. ZEVENY</b>			2a. DATE OF DEATH MONTH <b>JUNE</b> DAY <b>2</b> YEAR <b>1979</b>		2b. HOUR <b>M</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>MAY</b> DAY <b>3</b> YEAR <b>1921</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b> MD.	
10. CITY OR TOWN OF DEATH <b>Elkton</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supervisor-Aberdeen Proving</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Ground</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Maryland</b>	13b. COUNTY <b>Cecil</b>	13c. CITY OR TOWN <b>Elkton</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>2328 Blue Ball Road</b>	
14. FATHER'S NAME FIRST <b>Alexander</b> MIDDLE LAST <b>Zeveny</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Albina</b> MIDDLE LAST <b>Switski</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW II</b> <b>168-18-3010</b>		17. INFORMANT ADDRESS <b>Mrs. Pearl S. Zeveny, Elkton, Md.</b>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> <b>431-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>SEVERE HYPERTENSION</b> (c) <b>ARTERIO SCLEROSIS, GEN.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1975</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>6-1</b> , 19 <b>79</b> , to <b>6-2</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>6-2</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Rolando A. Najera</i>		22c. DATE SIGNED <b>6-2-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Rolando A. Najera, M.D.</b>		22e. ADDRESS <b>105 E. Main Street, Elkton, Md.</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>6/5/79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gilpin Manor Memorial Park, Elkton, Md.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR <b>HICKS HOME FOR FUNERALS, ELKTON, MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 8 1979</b>	
25b. REGISTRAR'S SIGNATURE <i>Patricia McCready</i>			

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elbert Beaumont Zimmerman					2a. DATE OF DEATH MONTH DAY YEAR June 22 1979		2b. HOUR 3:00A M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 2, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		7. UNDER 1 YEAR MONTHS DAYS # UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.				
10. CITY OR TOWN OF DEATH Perryville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC, Perry Point, Maryland				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY Retired		
13a. STATE Maryland					13b. COUNTY Howard		13c. CITY OR TOWN Columbia		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Barry B. Zimmerman					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora M. Miller					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW2		17. INFORMANT Evelyn Coulson, 10306 Donleigh Drive		ADDRESS Columbia, Md.				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic obstructive lung disease (emphysema)</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify (this hospital) attended the deceased from <b>October 2</b> , 19 <b>74</b> , to <b>June 22</b> , 19 <b>79</b> <del>XXXXXX</del> above, (I/we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Albert L. Mooney M.D.</b>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6-22-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. L. MOONEY, M.D.</b>					22e. ADDRESS <b>VA Medical Center, Perry Point, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/25/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>		23e. DATE REC'D. BY REGISTRAR		
24. FUNERAL DIRECTOR NAME <b>Witzke Funeral Home, Catonsville, Md.</b>					25. DATE REC'D. BY REGISTRAR <b>JUN 25 1979</b>		26. REGISTRAR'S SIGNATURE <i>John H. Brady</i>			

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North Carolina

North Carolina

North Carolina

North Carolina

North Carolina

North Carolina

North Carolina

Chronic obstructive lung disease (COPD)

North Carolina

North Carolina

North Carolina

North Carolina

North Carolina

North Carolina

VA Medical Center, Berry Point, MD

A. J. MOORE, M.D.

North Carolina

North Carolina

North Carolina

North Carolina

North Carolina

North Carolina

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH1. FOR  
STATE  
REGISTRAR

REG. NO.

7 9 1 4 9 1 6

1. DECEASED NAME (TYPE OR PRINT) <b>CHARLES (NMI) CECIL ZOHAS</b>			2a. DATE OF DEATH MONTH <b>5</b> DAY <b>18</b> YEAR <b>79</b>			2b. HOUR <b>11:05<sup>P</sup></b>					
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>1</b> DAY <b>1</b> YEAR <b>93</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		8. IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N/A Unknown</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b> MD.					
10. CITY OR TOWN OF DEATH <b>Elkton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Hospital of Cecil Co.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laurelwood Nursing Home</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Md.</b>		13b. CITY OR TOWN <b>Cecil</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>Laurelwood Nursing Home</b>					
14. FATHER'S NAME FIRST <b>Unknown</b> MIDDLE <b>Unknown</b> LAST <b>Unknown</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Unknown</b> MIDDLE <b>Unknown</b> LAST <b>Unknown</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-54-6033</b>		17. INFORMANT ADDRESS <b>State Hospital Mental Records &amp; Nursing Home</b>							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> <b>1889</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Squamous Cell Ca of bladder with invasion of skin</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>of skin</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Dementia Praecox</b>											
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b>5-1</b>		CITY OR TOWN <b>19 79</b>		COUNTY <b>5-18-</b>		STATE <b>19 79</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>5-1</b> 19 <b>79</b> to <b>5-18-</b> 19 <b>79</b> that (I) (we) last saw the deceased alive on <b>5-17</b> 19 <b>79</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Eddie S. Saw</b>				DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>5/22/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Eddie S. Saw</b>				22e. ADDRESS <b>Elkton, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5/22/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gilpin Manor Memorial Park, Elkton, Md.</b>		23d. LOCATION CITY OR TOWN <b>Elkton, Md.</b>		COUNTY <b>Elkton, Md.</b>		STATE <b>Elkton, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Hicks</b> ADDRESS <b>HICKS HOME FOR FUNERALS, ELKTON, MD.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 11 1979</b>							
				25b. REGISTRAR'S SIGNATURE <b>Henry McCurdy</b>							

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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